SEATTLE'S ELITE
PHYSICAL THERAPY

AUTHORIZATION OF USE AND DISCLOSURE FOR PRIVATE HEALTH INFORMATION

PATIENT NAME: _____

Hereby gives Seattle's Elite Physical Therapy my consent to inform my case worker/manager, insurance company, and doctor's office of my physical therapy progress and share protected health information for billing purposes. This includes phone conversations, faxes, progress reports, and doctor's prescriptions.

This authorization is effective through _____ unless revoked or terminated earlier by the patient or the patient's personal representative.

This authorization is effective for the following diagnosis(es):

_____

Additionally, Seattle's Elite Physical Therapy may speak to the following regarding my care:

Name _____

Relationship _____

The above authorization may include phone conversations, faxes, appointment information, doctor's prescriptions, notes/records and/or discussion of such. Information may include patient progress, appointment times, scheduled appointment dates, etc.

DO NOT release my information to the following: _____

I authorize Seattle's Elite Physical Therapy to leave a detailed message if necessary on my voice mail, answering machine, or with an individual. YES _____ NO _____

I have the right to revoke this authorization at any time by sending written notification to Seattle's Elite Physical Therapy at the above address. I understand that a revocation is not effective to the extent that Seattle's Elite Physical Therapy has relied on the use or disclosure of the protected health information. I also have the right to inspect or copy the protected health information to be used or disclosed as permitted under Federal Law (or Washington State Law to the extent the State Law provides greater access rights).

_____

Patient Name Patient Signature Date